



**Authorization and  
Release of Information /  
Consent to Records Disclosure**

I hereby authorize Marilyn Parker, or any other employee of the Lucas County Cross Systems Ombudsman Office, to inquire and obtain information on my behalf in all matters related to my complaint with

\_\_\_\_\_  
(Name of Agency)

I hereby direct \_\_\_\_\_ to release to the Office  
(Name of Agency)

of the Lucas County Cross Systems Ombudsman Office any and all information pertaining to my complaint, including information deemed confidential. A photocopy or fax of this authorization may be accepted in lieu of the original.

I understand that this release remains in effect during the time period that my complaint is being investigated (unless the time period exceeds 180 days) unless specifically revoked prior to this time period at in writing.

This release covers the time period between \_\_\_\_\_ and \_\_\_\_\_ and encompasses any and all records that the above named agency possesses.

**Purpose for Disclosure:** To allow the Ombudsman to obtain all information necessary for investigation of the complaint.

**Voluntary Statement:** I understand that authorizing the disclosure of this information is voluntary and that I can refuse to sign this authorization. This however, would inhibit a full and complete investigation by the Office of the Ombudsman.

**Termination:** I understand I have a right to cancel this authorization at any time by presenting a written notice to the Office of the Ombudsman. I understand that a cancellation will not apply to information that has already been released under this



**Lucas County Family and Children First Council  
Office of Cross System Ombudsman  
1946 N 13<sup>th</sup> Street, Suite 420  
Toledo, OH 43604**

authorization. This release will automatically expire in 180 days from the date of my signature below. I may be asked to sign a new authorization at that time.

**Confidentiality of Records and Re-Disclosure Statement:** I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance and Portability and Accountability Act of 1996 ("HIPPA") 45 C.F. R. Pts. 160 & 164, including any alcohol and/or drug treatment records and/or any other information relating to my past, present or future physical or mental health or condition, including HIV/AIDS testing, treatment or diagnosis is confidential and cannot be re-disclosed without my written consent unless otherwise provided for in regulation or law.

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Signature

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Print Name

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Date